Administered by:

Underwriting Company* (herein called the "Company"):

☐ CNA Group Life Assurance Company
☐ Continental Casualty Company

LTD EMPLOYEE'S STATEMENT

For assistance call: 1-800-303-9744

Use back to answer any questions where space does not permit. Return form to Employer.

Company Name		
Name (Last, first, middle initial)	Telephone No. (Include Area Code)	Date of Birth
Home Address (Street number, city, state, zip code)	Social Security Number	
Mailing Address, if different from Home Address (Street number, city, state, zip code)		

Marital Status ☐Single ☐Married ☐Divorced ☐Widowed	If married, Spouse's Name & Birth Date	Number of Dependent Children	Birth Date of Youngest Dependent:

Have you applied for or are you receiving benefits from:	Applied Yes	Applied No	Receiving Yes	Receiving No	Date Applied For	Amount Received Weekly	Amount Received Monthly	Effective Date	Paid Thru Date
a. Social Security	☐	☐	☐	☐					
b. Workers' Compensation	☐	☐	☐	☐					
c. State Disability Insurance	☐	☐	☐	☐					
d. Retirement or Pension	☐	☐	☐	☐					
e. Other	☐	☐	☐	☐					

***Please Attach copies of letters or notices related to these Other Benefits**

If due to injury, how and when did this accident occur?		Date first treated for this sickness or injury:
How does sickness/injury prevent you from returning to work?	Date last worked prior to current sickness/injury:	On what date were you able to or do you expect to return to work?

List primary physicians you consulted because of this disability. (Use other side if necessary)

Physician's Name	Address & Phone No. (Including Area Code)	Dates Treated
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.

List all hospital confinements for this disability. (Use other side if necessary)

Name of Hospital	Address	Date Confined
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.

IMPORTANT: THE FOLLOWING AUTHORIZATION MUST BE COMPLETED BY THE EMPLOYEE:

I AUTHORIZE The Hartford to release all of its collected health and financial information concerning me, including medical record information, for the purpose of evaluating my claim(s) for Life, Accident, or Disability Income benefits administered or insured by the The Hartford. I AUTHORIZE The Hartford to provide a complete copy of my claim file and/or information concerning my health and finances, claim status, or summaries thereof, to my employer through the appropriate employee benefit/human resources coordinators for the purpose of processing my claim(s) or for the proper administration of the employer's group benefit plan, including any disclosures which may be needed in order to facilitate my return to work with my employer. I further Authorize The Hartford to disclose any collected health or financial information, including medical record

information, to my employer's Workers' Compensation carrier, in the event I file a Workers' Compensation claim and such information is requested of The Hartford. I UNDERSTAND that I may receive a copy of this authorization and that this authorization is valid for the entire duration of my claim. I UNDERSTAND that I may revoke this Authorization at any time by providing written notice to The Hartford, except to the extent that an individual has taken action in reliance upon such authorization prior to notice of the revocation. I AGREE that a photographic copy of this authorization shall be as valid as the original.

Name (Please Print)	Signature	Date Signed

"Information Provider" as used herein may include any physician, medical practitioner, hospital, clinic, other medical or medically related facility, health plan, insurance or reinsuring company, agent, Health Claims Index, credit bureau or other consumer reporting agency, employer or employer benefit plan, Medical Information Bureau (MIB), Social Security Administration, Educational Institution, Government Agency or the Veterans Administration.

"Information" received from an Information Provider concerning the patient/claimant may include information relating to any advice, diagnosis, prognosis, treatment or care of my physical or mental condition, including information about any illness or injury, consultations, prescriptions or treatment, including x-ray plates and hospital records, records of drug or alcohol abuse and treatment, communicable disease, Human Immunodeficiency Virus (HIV) infection or Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted disease, mental illness (except psychotherapy notes), and/or financial, consumer report, or any other non-medical information regarding me.

I AUTHORIZE any Information Provider to give the Company, its legal representatives, its affiliated companies or its reinsurers, any and all Information regardless of any previous restriction or limitation on disclosure of such Information.

I UNDERSTAND that:

- the information obtained by use of this Authorization is at my request and will be collected by the Company to evaluate my claim for life, accident, and/or disability income benefits for which I may be entitled. I understand that benefits may be provided by a policy of insurance issued by the Company, or, as applicable, by a benefit plan provided by my employer for which the Company provides administrative services only. I understand that the information obtained by use of this Authorization may be used to administer any feature described in the policy of insurance or employer benefit plan, including evaluating return to employment opportunities with my employer.
- I understand that if I refuse to sign this Authorization it will not affect my ability to receive treatment from my physician or other healthcare provider.
- this Authorization shall remain valid for the duration of the claim.
- I may revoke this Authorization at any time by providing written notice to the Company, except to the extent that an individual has taken action in reliance upon such authorization prior to notice of the revocation.
- the Company may maintain or have access to personal information acquired separately through any of my insurance applications with the Company. I authorize the Company to use such information for evaluation of my claim.
- information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer the responsibility of the Information Provider or protected by the privacy rule under the Health Insurance Portability and Accountability Act.

I may request to receive a copy of this Authorization and I agree that a photographic copy of this Authorization shall be as valid as the original.

Name (Please Print)	Signature	Date Signed

****IMPORTANT NOTICE****

RESIDENTS OF ALL STATES EXCEPT AZ, CA, FL, NH & NJ: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or settlement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

AZ Residents: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CA Residents: For your protection California law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

FL Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NH Residents: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NJ Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Administered by:

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LTD PHYSICIAN'S STATEMENT

For assistance call: 1-800-303-9744

PLEASE PRINT – Use a separate sheet of paper to answer questions where space does not permit.

Patient's Name	Date of Birth
Patient's Address – Street, City, State, Zip Code	Phone Number (Area Code First)
Employer's Name	Policy Number

I hereby authorize release of information on this form , by the physician name on the second page or reverse side of this form for the purpose of claim processing.

Signature: ____ **Date:** ____________________________________

1. HISTORY

(a) When did symptoms first appear or accident happen? Month __________ Day _______ Year________

(b) Date of first visit: Month __________ Day _______ Year________

(c) Date you first advised patient to cease work: Month __________ Day _______ Year________

(d) Has patient ever had same or similar condition? ☐Yes ☐No
If yes, please state when and describe:

(e) Is condition due to injury or sickness arising out of patient's employment? ☐Yes ☐No ☐Unknown

2. MEDICAL CONDITION

(a) Diagnosis:

(b) Complications:

(c) Symptoms:

(d) OBJECTIVE FINDINGS (Please attach reports including x-rays, EKG's, Lab Data and any clinical findings):

3. NATURE OF TREATMENT

(a) What are the treatment plans?

(b) Surgery:

(c) Medications:

(d) Has this person been referred to another physician? ☐Yes ☐No
Name, address, phone & Fax # of this physician:

(e) Date of last visit: Month __________ Day _______ Year________

(f) Is further treatment required?

4. PHYSICAL LIMITATIONS
What are the specific limitations (i.e., lifting, standing, stooping)

5. Does this person have mental or nervous limitations? ☐ **Yes** ☐ **No**
If yes, please describe:

5. PROGNOSIS (Recovery and return to work date)

REMARKS:

Name (Physician) Please Print	Specialty	Telephone ( )
Address – Street, City or Town, State or Province, Zip Code		Fax ( )
Signature		Date

* The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life and Accident Insurance Company, Hartford Life Insurance Company and CNA Group Life Assurance Company (pending state approval of name change to “Hartford Life Group Insurance Company”).

Please return to Claimant.
For Assistance Call: 1-800-303-9744